Maine Department of Health and Human Services

DIVISION OF LICENSING AND REGULATORY SERVICES

MEDICAL FACILITIES UNIT

Application for Licensure / Relicensure of a Nursing Facility

Name of Facility: _____

Physical Location: _____

(Street/Road) (City/Town) (Zip) (County)

Mailing Address, if different: _____

Telephone Number: _____ **Fax Number**: _____

EMAIL ADDRESS: _____

Name of Administrator:

_____

Administrator License #: _____ **Expiration Date**: _____

Number and location of beds for each level of care:

	# of Beds	Location (Building, Ward, Wing, Floor)
Skilled (Medicare) Beds:	_____	_____
Nursing Facility Beds:	_____	_____
Dual Skilled/Nursing Beds:	_____	_____

Description of all structures and facilities forming any part of this institution:

_____

_____

_____

Utilities:

Water Supply: ☐ Public ☐ Private ***(If private, please include a copy of last water report)***

Sewage Disposal: _____

Name of Director of Nursing:

_____

Name of Medical Advisor/Director:

_____

Licensure fee:

$26.00 per bed. Please make your check or money order payable to the Treasurer, State of Maine, and mail it to:

Attention: Melissa Low, Office Associate II
Division of Licensing and Regulatory Services
Medical Facilities Unit
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011

I, _____, being duly authorized to assume responsibility for the conduct of the institution herein described, do hereby apply for a license to operate the facility and do agree to assume responsibility that the facility will comply with all current regulations of the Department of Health and Human Services.

_____
(Name of Administrator – Printed)

_____ _____
(Signature of Administrator) (Date)

_____
(Name of Owner [if different from above] – Printed)

_____ _____
(Signature of Owner) (Date)